Congressional Research Service

Memorandum

June 18, 2002

TO:

FROM: Chris L. Peterson and Christopher J. Sroka
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SUBJECT: **Comparison of Medicare Prescription Drug Plan Designs**

At your request, this memorandum provides the estimated insurance (or actuarial) value of adding prescription drug benefits to the Medicare program in the following plans:

- Blue Cross/Blue Shield's standard option as offered in the Federal Employees Health Benefits Program (FEHBP) in 2002, assuming all purchases are from preferred retail pharmacies (excluding the impact of a mail-order program, etc.);
- Medigap Plan H and Plan I, which have identical prescription drug benefits;
- Medigap Plan J; and
- the two proposals that you provided to us.

The middle column in **Table 1** summarizes the features of these plans' prescription drug benefits as modeled. The right column of the table provides the estimated actuarial value for each plan's prescription drug benefits if they were added to the current Medicare package. These values are estimates of what Medicare would pay out assuming 100% enrollment in the prescription drug plan. Consequently, we cannot adjust for take-up rates, premium amounts and other factors that a cost estimate would address.

The FEHBP plan benefit package used in this analysis is the Blue Cross/Blue Shield standard option plan for calendar year 2002. Nearly half of all FEHBP policyholders are enrolled in this plan, and about half of those enrollees are federal annuitants. (Annuitants include federal retirees under age 65 as well as those age 65 and over.) This analysis also includes the three standardized Medigap plans (out of 10) available to Medicare beneficiaries that offer prescription drugs (H, I and J). These three plans are also the most expensive Medigap plans.[1]

[1] For more information on supplemental Medigap plans, see CRS Report RL 31223, *Medicare: Supplementary "Medigap" Coverage*, by Jennifer O'Sullivan.

Table 1. Summary of Benefits and Cost Sharing: Illustrative Prescription Drug Benefit Structures and Values

Plan[a]	Benefits and Cost Sharing as Modeled	Est. Actuarial Value of Drug Benefit[b]
FEHBP Blue Cross/Blue Shield drug benefit	• No deductible • Plan pays 75% of drug costs • Plan pays for all drug costs above $16,000 ($4,000 maximum out-of-pocket)[c]	$2,100
Medigap plans H and I drug benefit	• $250 deductible • Plan pays for 50% of drug costs • Plan pays no more than $1,250 ($2,750 total drug spending)	$700
Medigap Plan J drug benefit	• $250 deductible • Plan pays for 50% of drug costs • Plan pays no more than $3,000 ($6,250 total drug spending)	$1,200
Drug Proposal 1	• $250 deductible • Plan pays for 80% of total drug costs between $251 and $1,000 • Plan pays for 50% of total drug costs between $1,001 and $2,000 • Plan pays for none of the drug costs between $2,001 and $4,900 • Plan pays for all drug costs above $4,900 (maximum out-of-pocket of $3,800)[d]	$1,300
Drug Proposal 2	• $100 deductible • Plan pays for 80% of total drug costs between $101 and $9,600 • Plan pays for all drug costs above $9,600 (maximum out-of-pocket of $2,000)	$2,200

Source: Congressional Research Service and the Hay Group, based on information from the requester for Drug Proposals 1 and 2, as well as from Blue Cross and Blue Shield Service Benefit Plan: 2002 FEHBP brochure; Medigap drug benefits from CRS Report RL31223, *Medicare: Supplementary "Medigap" Coverage*, by Jennifer O'Sullivan.

[a] For comparative purposes, we assume a 2% administrative factor, no mail-order program, and no savings from formularies, pharmacy benefit managers (PBMs), or incentives regarding the use of generic versus brand-name drugs. For the FEHBP Blue Cross/Blue Shield plan, we assume all purchases are at a preferred retail pharmacy.
[b] The model estimates the average amount paid by the plan for Medicare beneficiaries. In other words, the model makes its calculation based on 100% enrollment by Medicare beneficiaries. The body of this memorandum provides a description of "actuarial value" and limitations of estimates.
[c] The FEHBP Blue Cross/Blue Shield plan standard option has an overall out-of-pocket maximum of $4,000 for *all* covered services. While only the prescription drug portion of this plan is included in the model, we assume a $4,000 out-of-pocket maximum for this prescription drug plan. An enrollee in the actual FEHBP Blue Cross/Blue Shield plan would likely reach the plan's out-of-pocket maximum before having $4,000 in out-of-pocket drug spending ($16,000 in total drug spending). However, even when lowering the out-of-pocket prescription drug maximum by modest amounts, the estimated value of the plan does not change substantially.
[d] In the model, we considered *all* cost-sharing "out of pocket," regardless of whether it was reimbursed by supplementary coverage or from any other source. If cost-sharing reimbursed by another source did not count toward the out-of-pocket maximum, on average, this would raise the effective amount of total drug spending necessary before the out-of-pocket maximum was obtained. This would likely lower the plan's actuarial value.

Model Description and Assumptions. Using a computer model created for the Congressional Research Service (CRS) by the Hay Group, an employee benefit and actuarial firm, CRS can estimate the value of different health insurance benefit packages for the Medicare population. The model is based on the health care utilization and expenditure data from the 1994 Medicare Current Beneficiary Survey (MCBS), with expenditures updated to 2002 dollar amounts. It must be noted that utilization and costs of prescription drugs and other health care for seniors in 1994 may differ from those of seniors today, even when inflated to 2002 levels.

To a major extent, the quantity and type of health care that people use is influenced by the price they must pay when they use care. To evaluate how different benefit and cost-sharing provisions would affect Medicare beneficiaries' utilization of health care, assumptions must be made about how beneficiaries would respond to different cost-sharing requirements. The factors in the model that adjust prescription drug utilization for changes in cost sharing were developed by the Centers for Medicare and Medicaid Services based on the RAND Health Insurance Experiment that took place in the 1970s. The RAND findings are still the best available data for evaluation of how different levels of enrollee cost sharing influence health care utilization patterns.

Important features of private prescription drug plans like the FEHBP's Blue Cross/Blue Shield plan that we do not estimate are the effects of formularies, pharmacy benefit managers (PBMs), mail-order programs, and incentives regarding the use of generic medications. Furthermore, because most outpatient prescription drugs are not covered by Medicare, coordination rules (e.g., "first payer" and "second payer" rules) presently do not exist but would need to be developed if a prescription drug benefit were added. It is difficult to predict what such rules may entail and what their impact would be. For example, a new drug coverage plan for Medicare beneficiaries might include policies aimed at minimizing displacement of non-Medicare drug coverage. Experience with Medicare covered services shows that many plan sponsors continue to provide secondary coverage when benefits are added to the Medicare package. If the Medicare drug coverage is sufficiently broad, it would be reasonable to expect that many plan sponsors would reduce their benefit payments. However, building on the Medicare coordination-of-benefits experience, we would not expect all sponsors to terminate their plans. Therefore in developing the expected value of the drug plan, we have assumed that beneficiaries with other coverage would continue to have 50% of the expenses not covered by Medicare paid by the other coverage.

Illustrative Values. The right column in **Table 1** shows the annual actuarial (or insurance) value of each of the plans. These values can be thought of as an estimate of the average per-enrollee payment by the plan based on the experiences of and cost-sharing faced by all Medicare beneficiaries.[2] In other words, these values represent the amount that the plan would pay in benefits for each enrollee *assuming all Medicare beneficiaries enrolled.* Thus, the value does not include out-of-pocket beneficiary cost-sharing (e.g., deductibles and copayments), although the model does adjust for the impact of such cost-sharing on utilization. The value also does not take into account the premium that may be charged to the beneficiary nor its impact on utilization. Thus, while the analysis includes illustrations of the insurance value of the prescription drug benefits, it does not and cannot provide cost estimates. Besides assuming 100% enrollment by beneficiaries and lacking the ability to

[2] Of course, not all enrollees will receive the estimated actuarial value of the plan. Because the actuarial value is an average, some enrollees will receive benefits above the actuarial value while others will receive benefits below the actuarial value.

account for changes in utilization because of premium amounts, the model cannot adjust for take-up rates and other factors that a cost estimate would address. The benefit values are intended to be illustrative only and to show relative differences.

The model calculates the annual value of the current Medicare fee-for-service program per enrolled beneficiary as approximately $6,300 in 2002 (again, this value excludes enrollee cost sharing and any impact from premiums). It includes all current Part A and Part B covered benefits, which excludes most outpatient prescription drugs.

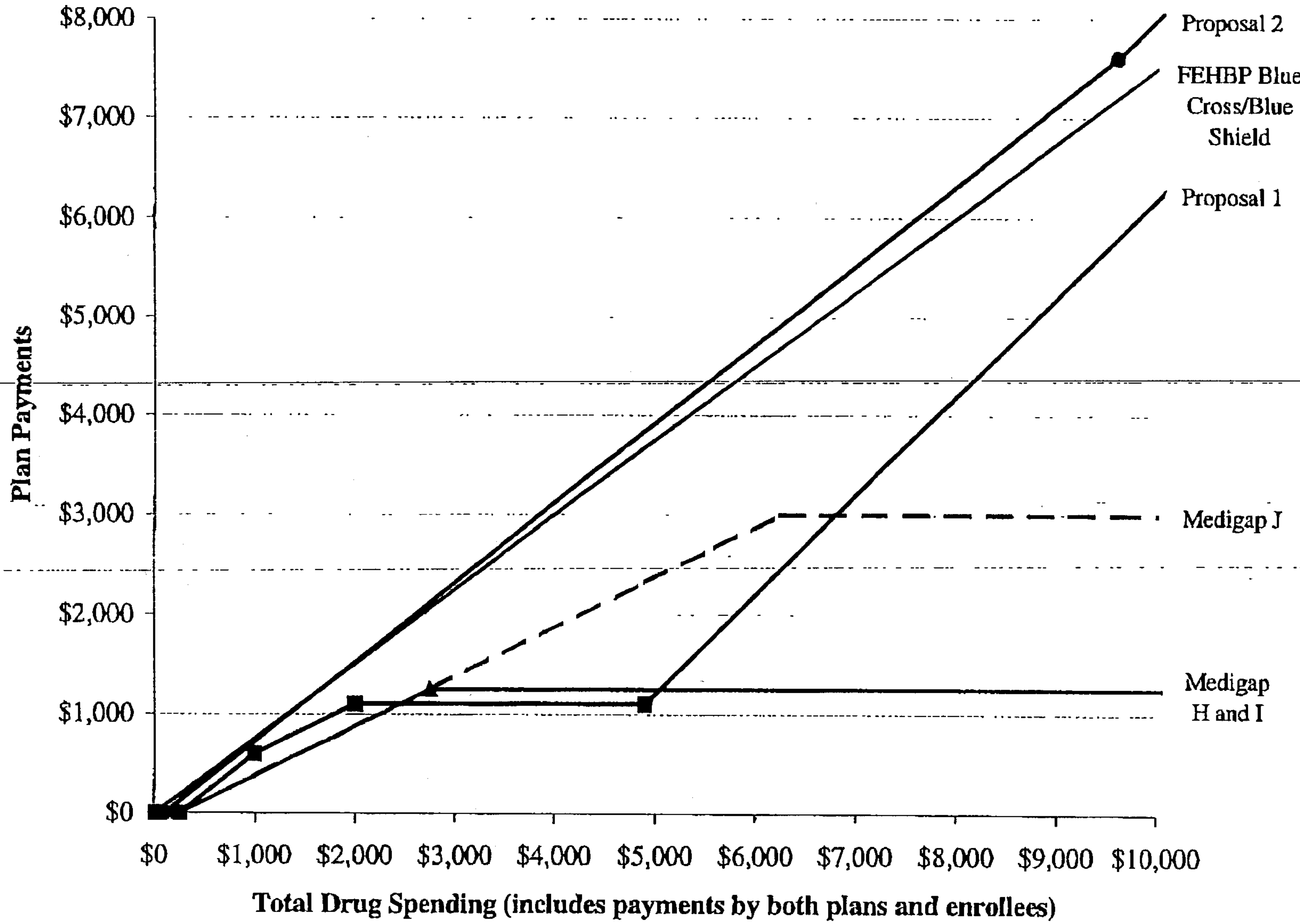
The model results summarized in **Table 1** indicate that a prescription drug benefit similar to that in the FEHBP Blue Cross/Blue Shield plan would increase the insurance value of Medicare by about $2,100 per beneficiary per year in 2002 dollars. This is the amount paid by the plan and does not include beneficiaries' cost-sharing; thus, total spending on prescription drugs would be higher than $2,100. A prescription drug benefit like that in Medigap standardized plans H and I would increase the insurance value of Medicare by about $700 per beneficiary per year. Adding Medigap standardized Plan J to Medicare would increase its insurance value by about $1,200 per beneficiary per year. Drug Proposal 1 would increase the insurance value of Medicare by about $1,300 per beneficiary per year. Drug Proposal 2 would increase the insurance value of Medicare by about $2,200 per beneficiary per year.

As shown in **Table 1**, the values of the drug benefits in the FEHBP Blue Cross/Blue Shield plan and Drug Proposal 2 are similar ($2,100 and $2,200, respectively), as are the values of the drug benefits in Medigap Plan J and Drug Proposal 1 ($1,200 and $1,300, respectively). While the actuarial values may be similar, an individual enrollee's experience in these plans may be very different because of the structure of the plans' benefits and resulting cost-sharing as well as the enrollees' level of *total* drug spending (that is, the plan's payment plus the enrollees' payment). **Figure 1** illustrates the plans' payments at different levels of total drug spending, based on the cost-sharing listed in **Table 1**. (**Figure 1** displays total prescription drug spending up to $10,000, although some enrollees may have spending exceeding that amount.) So, while Medigap Plan J and Drug Proposal 1 have similar estimated insurance values ($1,200 and $1,300), this does not mean that every enrollee would have similar out-of-pocket spending on drugs in each plan. For example, when total drug spending exceeds $6,250, enrollees in Medigap Plan J must cover all of those costs. On the other hand, enrollees in Drug Proposal 1 would have to pay for *none* of the prescription drug expenditures above $4,900. Thus, enrollees with a choice of plans would need to decide which is better for them given their expected drug costs, even though the average experience for Medicare beneficiaries would be similar in each.

As displayed in **Figure 1**, Drug Proposal 1 would pay more toward drug costs for enrollees with total drug spending between $250 and $2,450, compared to Medigap Plan J. Drug Proposal 1 would also pay more for enrollees whose total prescription drug costs exceed $6,800. However, Medigap Plan J would pay more toward coverage when total drug spending is between $2,450 and $6,800. In the aggregate, the differences in these plans nearly offset when applied to the entire Medicare population and yield similar estimated actuarial values. Again, this does not mean that the plans would be similar for all enrollees.

We hope that this memorandum is helpful. If you would like additional assistance, please do not hesitate to call Chris Peterson (7-4681) or Hinda Chaikind (7-7569).

Figure 1. Plan Payments at Different Levels of Total Drug Spending



Source: Congressional Research Service, based on information from the requester for Drug Proposals 1 and 2, as well as from Blue Cross and Blue Shield Service Benefit Plan: 2002 FEHBP brochure; Medigap drug benefits from CRS Report RL31223, *Medicare: Supplementary "Medigap" Coverage*, by Jennifer O'Sullivan.